

General Information for Authorization

Octaios votaman	34241					r			
Org 1. :	g 1.508			Service Type		2. T			
Client Information									
Name 3. CLIENT NAME						Client ID		4. 123456789WA	
Living Arrangements 5.				Reference Au	ith#	6.			
	Provider Information								
Requesting	g NPI#	7. 1123456789				Requesting Fa	ax#	8. XXXXXXXXXX	
Servicing NPI # 9. 1123456789				Name		10. SERVICING PROVIDER NAME			
Referring N	VPI#	11. 1123450	5789			Referring Fax	#.	12. XXXXXXXXX	
Service Sta		13.						14. N/A	
Date:									
				Se	rvice Requ	est Information	1		
Description	n of service be	ing requeste	d:		1.1.1.1.1.1.1				
15. Additi	ional Physicia	ıl therapy				16. N/A	1	17. N/A	
18. Serial /	/NEA# N/A					19. N/A			
20. Code Qualifier	Code 21. National 22. Mod		23. # Units/Days 24. \$ Am Requested Reques		ount ted			26. Tooth or Quad #	
С	97012-97750)		96	N/A		N/A		N/A
	•								
		-							
			<u> </u>						
		1		T		nformation			·
Diagnosis Code 27. ICD-9 Diagnosis r			s name	28.					
Place of service 29.									
30. Comm	ents:								

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The material in this facsimile transmission is intended only for the use of the individual to who it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. <u>HIPAA Compliance</u>: Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to see insurance payment, or to perform other specific health care operations.

Instructions to fill out the General Information for Authorization form, DSHS 13-835

FIELD	NAME	ACTION ALL FIELDS MUST BE TYPED.						
	Org required	Enter the Number that Matches the Program/Unit for the Request						
1		500 - Division of Alcohol and Substance Abuse (DASA) 501 - Dental 502 - Durable Medical Equipment (DME) 509 - Economic Services Administration (ESA) (DSHS) 504 - Home Health 505 - Hospice 506 - Inpatient Hospital 507 - Juvenile Rehabilitation Administration (JRA) (DSHS) 508 - Medical 509 - Medical Nutrition 510 - Mental Health 511 - Outpt Proc/Diag 513 - Physical Medicine & Rehabilitation (PM & R) 514 - Aging and Disability Services Administration (ADSA) 515 - Transportation 516 - Miscellaneous						
	Service Type required	Enter th	e letter(s) in all CAPS that represe	nt the ser	vice type you are requesting.			
		AA BB BEM	Ambulatory Aids Bath Bench Bath Equipment (misc)	OS OTC PAS	Orthopedic Shoes Orthotics PAS			
		BGM BGS BP	Blood Glucose Monitors Bone Growth Stimulator Breast Pumps	PDN Private PHY	Duty Nursing Pharmacy			
		BS BSS2	Bariatric surgery Bariatric surgery stage 2	PL PMR	Patient Lifts PM and R			
		C CI	Commode Cochlear Implants	PROS PRS	Prosthetics Prone Standers			
		CIERP		PSY PTL	Psychotherapy Partial			
		CWN	Crowns	PWH	Power Wheelchair - Home			
		DASA DEN	DASA Dentures	PWNF PWNF	Power Wheelchair – NF Power Wheelchair - NF			
		EN	Enteral Nutrition	PHYS	Physician Services			
		ESA	ESA	R	Respiratory			
2		FSFS	Floor Sitter/Feeder Seat	RB\$	Rebases			
		HB	Hospital Beds	RE	Room equipment			
		HEA HH	Hearing Aids Home Health	RLNS RM	Relines Readmission			
		HSPC	Hospice	S	Surgery			
		IPT	Infusion/Parental Therapy	SBS	Specialty Beds/Surfaces			
		ITA	Inpatient·admission - ITA	SC	Shower chairs			
		JRA	JRA	SÇAN	MRI/PET Scans			
		LTAC	LTAC	SF	Standing Frames			
		MC	Medication	SGD	Speech Generating Device			
		MISC MN	Miscellaneous Medical Nutrition	SSIP T	Short Stay (In-Patient) Therapies (PT/OT/ST)			
		MWH	Manual Wheelchair - Home	TRN	Transportation			
		MWNF	Manual Wheelchair - NF	TU	TENS Units			
•		0	Other	US	Urinary Supplies			
		ODC	Orthodontic	V	Vision			
		ODME	Other DME	VNSS	Vagus nerve stimulator surgery			
		OOS OP	Out of State Ostomy Products	VOL WDCS	Inpatient admission-Voluntary Wound/decubiti care supplies			

3	Name: Required.	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
	Client ID: Required.	Enter the client ID = 9 numbers followed by WA.
4		 For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions). A reference PA will be built with a placeholder client ID. If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the Client ID. The PA will be updated and you will be able to bill the services approved.
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: Required.	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Servicing NPI #: Required.	The 10 digit numeric number that has been assigned to the billing/servicing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit numeric number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: Required.	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA# to access the x-rays for this request.
20	Code Qualifier: Required.	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S - ICD-9/10 Diagnosis Code
21	National Code: Required.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: Required.	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific <u>Billing Instructions</u> for the appropriate unit/day designation for the service code entered).
24	\$ Amount Requested: Required.	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific <u>Billing Instructions</u> and <u>fee schedules</u> for assistance) Must be entered in dollars & cents with a decimal (e.g. \$400 should be entered as 400.00.
25	Part # (DME only): Required for all "By Report" codes requested.	Enter the manufacturer part # of the item requested.

26	Tooth or Quad#: Required for dental requests	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-36, A-T, AS-TS, 51-82 and SN
27	Diagnosis Code	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service	Enter the appropriate two digit place of service code.
30	Comments	Enter any free form information you deem necessary.

Field	Name	Action	
		ALL FIELD	OS MUST BE TYPED
	Org required	Enter the Nu	mber that Matches the Program/Unit for the Request
		500 Divisio	on of Alcohol and Substance Abuse (DASA)
-		501 Dental	· · · · · · · · · · · · · · · · · · ·
		l .	le Medical Equipment (DME)
			mic Services Administration (ESA) (DSHS)
		504 - Home	` /` /
		505 - Hospic	
	·	506 - Inpatie	
			le Rehabilitation Administration (JRA) (DSHS)
1		1	
		508 - Me	
			eal Nutrition
		510 - Ment e	al Health
		511 - Outpt	
			al Medicine & Rehabilitation (PM & R)
			and Disability Services Administration (ADSA)
		515 Transp	
	·	516 - Miseel	laneous
	Service Type required	1	ter(s) in all CAPS that represent the service type you are
		requesting.	
			A 5 1 . 111
		AA	Ambulatory Aids
		BB	Bath Bench
		BEM	Bath Equipment (misc)
		BGM	Blood Glucose Monitors
	·	BGS	Bone Growth Stimulator
·		BP	Breast Pumps
		BS	Bariatric surgery
		BSS2	Bariatric surgery stage 2
		E	Commode
		CI .	Cochlear Implants
_		CIERP	Cochlear Implant Ext Repl Prts
2		CSC	Commode/Shower Chair
	·	CWN	Crowns
		DASA	DASA
		DEN	Dentures Division 124
		EN	Enteral Nutrition
		ESA	ESA
		FSFS	Floor Sitter/Feeder Seat
		HB HB	Hospital Beds
İ		HEA	Hearing Aids
		HH	Home-Health
		HSPC	Hospice
		PT .	Infusion/Parental Therapy
		ITA	Inpatient admission—ITA
		JRA	JRA
		LTAC	LTAC

Field	Name	Action	
		MC	Medication
		MISC	Miscellaneous
		MN	Medical Nutrition
		MWH	Manual Wheelchair - Home
	•	MWNF	Manual Wheelchair NF
		0	Other
	·	ODC	Orthodontic
_		ODME	Other DME
		008	Out of State
	·	OP	Ostomy Products
		OS	Orthopedic Shoes
		OTC	Orthotics
		PAS	PAS
		PDN	Private Duty Nursing
		PHY	Pharmacy
		PL	Patient Lifts
		PMR	PM and R
		PROS	Prosthetics
		PRS	Prone Standers
		PSY	Psychotherapy
		PTL	Partial
		PWH	Power Wheelchair Home
		PWNF	Power Wheelchair - NF
		PWNF	Power Wheelchair - NF
		PHYS	Physician Services
		R	Respiratory
		RBS	Rebases
		RE	Room equipment
		RLNS	Relines
		RM	Readmission
		S	Surgery
		SBS	Specialty Beds/Surfaces
		SC SC	Shower chairs
		SCAN	MRI/PET Scans
		SF	Standing Frames
		SGD	Speech Generating Device
		SSIP	Short Stay (In-Patient)
		T	Therapies (PT/OT/ST)
		TRN	Transportation
		TU	TENS Units
		US	Urinary Supplies
		¥	Vision
		VNSS	Vagus nerve stimulator surgery
		VOL	Inpatient admission-Voluntary
		WDCS	Wound/decubiti-care-supplies
2	Name: Required.	<u> </u>	st name, first name, and middle initial of the patient you
3	*		ng authorization for.
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4	A		· - , · · · ·

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5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc. NOT REQUIRED FOR THERAPIES
6	Reference Auth #:	If requesting a change or extension to an existing authorization, please indicate the number in this field.
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24	\$ Amount Requested: Required.	NOT REQUIRED FOR THERAPIES Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee schedules for assistance) Must be entered in dollars & cents with a decimal (e.g.

Field	Name	Action
		\$400 should be entered as 400.00.
25	Part # (DME only): Required for	NOT REQUIRED FOR HEARING AIDS Enter the manufacturer
2.5	all "By Report" codes requested.	part # of the item requested.
	Tooth or Quad#: Required for	NOT REQUIRED FOR HEARING AIDS
	dental requests	Enter the tooth or quad number as listed below:
		QUAD
		00 full mouth
		01 upper arch
26		02 lower arch
20		10 upper right quadrant
		20 — upper left quadrant
		30 lower left quadrant
·		4 0 lower right quadrant
		Tooth # 1-36, A-T, AS-TS, 51-82 and SN
. 27	Diagnosis Code:	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service .	Enter the appropriate two digit place of service code.
49		Use 11 for office or 22 for outpatient hospital.
30	Comments:	Enter any free form information you deem necessary.

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